



**MISSISSIPPI
BOARD OF EXAMINERS
FOR SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS**

LMSW SUPERVISION 4TH EVALUATION CHECKLIST

Congratulations on reaching your last and final supervision period. Listed below are items that must be submitted to our office for Board approval before you are able to sit for the exam. Once your file is reviewed and approved, you will be sent an exam approval letter.

- ☐ Initial Application (Form 266) and Processing Fee (\$27.00 money order or cashier's check only) -**Valid one year from the date stamped received by the Board office**
- ☐ Supervision Evaluation Form
- ☐ Verification of Face to Face Client Contact Form
- ☐ Termination of Supervision Form
- ☐ Three Reference Forms (**you will need to print 3 copies of this form**)

After you pass the ASWB exam, your test score will be forwarded to the Board office within 2 weeks after completing the exam. This step does not automatically upgrade you to LCSW. Your file will be reviewed for approval before you are issued your LCSW license. To complete the process for LCSW licensure, you must submit the following:

- ☐ Request for Fingerprint Card Form - Please submit this form to request a fingerprint card and \$50.00, money order or cashier's check only. Upon the Board receiving the form with fee, a fingerprint card will be mailed to you with instructions.
- ☐ Initial License (Upgrade) Fee - \$32 upgrade fee LMSW to LCSW

The \$50.00 background check fee and the \$32.00 upgrade fee can be combined for a total of \$82.00 and submitted with the request for fingerprint card form.

Social Work Initial License Application

(Please type or print in ink)

Date: _____ (Please use legal name that is identified on your Driver's license or Social Security Card)

Name: _____

(Last)

(First)

(Middle/Maiden)

Mailing Address: _____ Contact No. (____) _____ - _____

(City)

(State)

(Zip Code)

(County)

Email Address: _____

Social Security Number: - - Date of Birth - - Race: _____ Sex: Male ☐ Female ☐ U.S. Citizen: No ☐ Yes ☐ Legal Alien: No ☐ Yes ☐

Place of Employment: _____ Telephone No. (____) _____ - _____

Public Agency ☐ Private Agency ☐ Title of Position: _____Business Address: _____
(Street/PO Box) (City) (State) (Zip Code) (County)If upgrading, give license number: - 1. By which method are you seeking licensure: ☐ Examination ☐ Reciprocity/Endorsement2. License applying for (check one) See regulation for qualifications at each level. Social Worker (LSW) ☐
Master Social Worker (LMSW) ☐
Certified Social Worker (LCSW) ☐3. Have you ever been licensed as a social worker in this state?
If yes, what was your license number: _____No ☐ Yes ☐4. Have you ever been licensed or registered as a social worker in another state?
If yes, complete the Reciprocity Information/ Endorsement Form and send it to the state(s) of current or previous licensure.No ☐ Yes ☐

5. Which social work degree do you possess: _____ BSW _____ MSW _____ N/A (Student)

6. Is your school accredited by _____ CSWE _____ SACS _____ BOTH

Initial Application Fee: \$27.00 (make cashier's check or money order payable to MSBOE SW/MFT)**(FEES ARE NON-REFUNDABLE)****For Office Use Only:**

CC, MO, TC, OC #: _____ Amount: \$ _____ Date: _____

Name on payment, if different from licensee: _____

(Continue on Back of This Form)

MISSISSIPPI BOARD OF EXAMINERS FOR SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS

7. Have you **ever** been found in violation of laws or rules pertaining to professional practice or settled such charges prior to a formal finding in an administrative proceeding? No ☐ Yes ☐
8. Have you ever had a record expunged from a felony or any criminal conviction? No ☐ Yes ☐
9. Have you ever had a professional license revoked, suspended, or encumbered in any way? If yes, has the decree changed? Attach a full explanation. No ☐ Yes ☐
10. Has any court ever declared you mentally incompetent? If yes, attach a full explanation. No ☐ Yes ☐
11. Have you ever been arrested, or charged, or sentenced for any misdemeanor or criminal Offense. Received deferred judgement for the commission of a felony, or any crime involving moral turpitude in the United States or foreign country? If yes, attached a full explanation. No ☐ Yes ☐
12. Have you knowingly failed to renew a license during investigation or disciplinary action? No ☐ Yes ☐
13. Are there any pending charges against you? No ☐ Yes ☐
14. **I understand that licensure as a social worker requires additional information to be completed and submitted to the Board for review and that a passing score on the ASWB examination does not automatically qualify me to become licensed.** No ☐ Yes ☐
15. **I understand that I have one year from the date of the approval letter to sit for the ASWB exam and that my application for licensure will expire if I have not passed the exam and a new application will be submitted before I am approved to retake the exam.** No ☐ Yes ☐

(Notary Seal)

Subscribed and sworn to before me this _____ day of

_____, 20____.

My commission expires on _____.

Notary Public

I, the undersigned, do hereby solemnly swear or affirm that I am the above applicant, and that the statements contained therein or accompanying this application are true to the best of my knowledge and belief. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Board. I also agree to uphold the laws and standards of conduct set forth in the laws of the State of Mississippi as pertain to the practice of Social Work

Applicant's Signature

Date

Complete form, make payment payable to **MBOE SW/MFT** and mail to:

**MS Board of Examiners for SW/MFT
Post Office Box 4508
Jackson, MS 39296-4508**

**Current
Passport-Like Photo of You
Facing Forward**

(Application cannot be processed without photo. Photocopies will not be accepted. The photo must be an original of you facing forward.)

Full legal name of Supervisee _____

Supervisor _____

Address _____

LCSW Supervisor No. _____

Date Completed _____

Work telephone number _____

Attachment C

Termination of Supervision

General Instructions to supervisors completing this form:

A. Please complete all items.

B. The Board assumes that you, in recommending this candidate, will be willing to substantiate to the Board your recommendation, should this Board desire to contact you at a later date.

I, _____, licensed certified social worker number _____, certify that I supervised _____ in the field of social work while he/she was employed at _____, from _____ to _____, who worked _____ hours per week. I gave _____ hours of supervision per week for a total of _____ hours of supervision (face to face _____ alternate _____)

1. Title of Supervisee's Position: _____

2. Supervisee's duties and responsibilities: _____

3. Reason for termination of supervision: _____

4. Extent of knowledge of supervisee's professional and ethical behaviors:

☐ Limited

☐ Moderate

☐ Thorough

5. Please check the appropriate box if supervision has been given for at least two (2) years and the supervisee has completed 100 hours of supervision at one (1) hour per week.

☐ I highly recommend

☐ I recommend with reservation

☐ I recommend

☐ I do not recommend

the supervisee for licensed certified social worker. (Attach an explanation if you checked, I recommend with reservation or I do not recommend.)

6. Please submit a completed evaluation form along with this Termination of Supervision.

(Continued on back of this form)

Supervisors Information

Name and title of Supervisor: _____
(please print)

Employment address: _____
(Company)

(Street address)

(City) (State) (Zip)

Work Telephone number: _____

Number of applicants I am supervising at this time: _____

Signature of supervisor: _____ Date: _____

Comments:

After completion, mail to:

Board of Examiners
P. O. Box 4508
Jackson, MS 39296-4508

VERIFICATION OF FACE TO FACE CLIENT CONTACT

Notice to Applicant: Please complete the first section of this form and send a copy to the director or supervisor of each practice site or agency in which you practiced social work following the receipt of the master's or doctoral degree in social work. You need documentation of at least a minimum of one-thousand (1000) hours of face to face client contact.

I. TO BE COMPLETED BY THE APPLICANT

Applicant's Name _____ SS# _____ - _____ - _____

Address _____
Street City State Zip Phone

Practice Site or Agency _____

Address _____
Street City State Zip Phone

Position/Title _____

Description of Responsibilities _____

Dates of Practice: From _____ To _____
Month/Year Month/Year

Total weeks of practice at this site: _____ Average clinical hours/week _____

Total client contact hours at this site: Individual _____ Groups _____ Total hour _____

Oath and Authorization to Release

I attest that the above information is a true and accurate representation of my experience in the clinical practice of social work at the above site. Further, I authorize the above agency, director or supervisor to release the requested information.

Signature of Applicant

Printed Name

Date

Continued on reverse side

II. TO BE COMPLETED BY PRACTICE SITE DIRECTOR OR SUPERVISOR

Please review the applicant's description of his/her clinical practice of social work at your site/agency. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide that information below:

I attest that I served as (please indicate) director or supervisor for the applicant during the clinical experience described above and that this description is a true and accurate representation of the applicant's clinical experience in marriage and family therapy at this site.

Director or Supervisor's Signature	Printed Name	Date
<hr/>		
Name of Site		Phone
<hr/>		
Address	City	State Zip
<hr/>		

(If the director or supervisor who worked with the applicant cannot be located, the current director or supervisor may verify the applicant's experience based on a review of the available records.)

After a diligent and thorough search of available records, I attest that this description is a true and accurate record of this applicant's clinical experience in marriage and family therapy at this site.

Director or Supervisor's Signature	Printed Name	Date
<hr/>		
Name of Site		Phone
<hr/>		
Address	City	State Zip
<hr/>		

Please return this completed form directly to the following Board address:

**Mississippi Board of Examiners for
Social Workers and Marriage & Family Therapists
P.O. Box 4508 * Jackson, MS 39296-4508**

Mississippi
Board of Examiners for Social Workers and Marriage & Family Therapists
P.O. Box 4508 * Jackson, MS 39296-4508

**CONFIDENTIAL PROFESSIONAL REFERENCE FOR
LCSW CANDIDATE FOR LICENSURE**

Notice to Applicant: Applicant for LCSW must submit with the final evaluation forms, three (3) complete professional references from appropriate professionals. **One (1) must be completed by a LCSW. THE LCSW SUPERVISOR WHO HAS BEEN IN A CONTRACT WITH THE APPLICANT BELOW CANNOT OR MUST NOT COMPLETE THIS FORM.**

I. TO BE COMPLETED BY THE APPLICANT

Name of Applicant _____
Last First Middle Maiden (if applicable)

Address _____
Street City State Zip Phone

I hereby authorize _____ to release the requested information.

Applicant Signature Date

+++++

II. TO BE COMPLETED BY LICENSED MENTAL HEALTH PROFESSIONAL

1. How long have you known the applicant? _____
2. In what capacity have you known the applicant? _____

3. During what time period have you had an opportunity to observe directly the applicant=s clinical practice? _____

4. Based on your personal knowledge and observation, I believe the applicant has: (mark one) Poor____, Marginal____, Average____, Good____, Outstanding____, qualifications and skills to practice as an Licensed Certified Social Worker (LCSW).
5. To the best of your knowledge, has the applicant=s license, clinical privileges, professional association membership, or other professional status ever been denied, challenged, suspended revoked, modified, or voluntarily surrendered in lieu of disciplinary action? Yes No
6. To the best of your knowledge, is there any disciplinary action pending against the applicant? Yes No

7. To the best of your knowledge, has the applicant ever had a suit filed against him/her or entered into a malpractice settlement related to the professional practice? Yes No
8. To the best of your knowledge, has the applicant ever been arrested, charged, sentenced, or received a deferred judgment for the commission of a felony, or any crime of moral turpitude in the United States or a foreign country? Yes No
9. To the best of your knowledge, is the applicant now, or has he/she been at any time during the past five (5) years, unable to practice a profession with reasonable skill and safety to clients, due to any illness, mental or physical condition, or the use of alcohol, drugs, narcotics, chemicals or any other material?
Yes No

If you answered YES to any of the preceding questions 5 through 9, please attach a full explanation to this form.

10. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide the information below:

11. How would you summarize your recommendation of this applicant for licensure as a licensed certified social worker?

☐ Recommend without reservation
☐ Recommend
☐ Would not recommend
☐ Unable to make a judgment

Signature of Reference	Printed Name	Title	Date
Your Discipline	Type of License	License#	Expiration Date
Street Address	City	State	Zip Phone

Please return the completed form directly to the Board at:

**Mississippi
Board of Examiners for
Social Workers and Marriage & Family Therapists
P.O. Box 4508 * Jackson, MS 39296-4508**

Thank you for your assistance.

Evaluation # 1 2 3 4 (circle your answer)

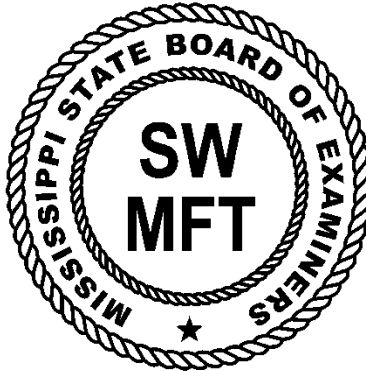
Supervisee's Name: _____ License# _____

Supervisee's Email Address: _____

Supervisor: _____ Supervisor# _____

Supervisor's Email Address: _____

Date Completed: _____



LCSW SUPERVISION EVALUATION FORM

MISSISSIPPI
BOARD OF EXAMINERS
FOR SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS

P.O. Box 4508 * Jackson, MS 39296-4508 * 601- 987-6806

www.swmft.ms.gov

Each are of performance should be rated by circling the number that most accurately describes the performance of the supervisee. In the evaluation form, the word ‘client’ is a generic term representing individuals, groups, agencies, and/or communities.

(This source of evaluation is used by permission of the Louisiana State Board of Certified Social Work Examiners.)

1. Quality of social work performance in relation to other professionals and or agencies; generates respect and productive client oriented outcomes from interactions with other professionals and or agencies rather than allowing subjectivity and or work mood to interfere with work and professional performance.

0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Frequent substantiated complaints about quality of services or behavior which has negative impact on client systems, social work profession, professional/personal reputation, other professionals and agencies.		Has occasional problems which conflict with professional or agency standards resulting in negative consequences.		Quality of work performance remains at an acceptable level when problems interfere with work performance initiates corrective action.		Work performance and relationships with other professionals and agencies have productive outcomes.		Demonstrates exemplary work performance and relationships which are frequently substantiated in formal and informal contacts with other clients/agencies/professionals.	

2. Ability to prepare for and use supervision: recognizes and accepts role of learner; reflects on and generalizes learning from one experience to another; profitably uses supervisor feedback.

0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Accepts supervision only when forced, attitude remains negative.		Uses scheduled supervisory conferences, but is reluctant to seek help. Non-spontaneous towards supervision.		Prepares for scheduled conferences and initiates conferences. Performance indicates use of supervisory interchange.		Is consistently prepared for supervision; work indicates maximum use of supervision.		Creative. Able to present thoughtful, detailed analysis of options to supervisor. Realistic in accepting limitations in resources.	

3. Commitment to social work profession, its values and ethics.

0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Makes derogatory comments about the profession; does not adhere to basic social work values; violates ethical standards.		Sometimes positive in attitudes towards profession. Usually is guided in professional practice by social work value base usually does not violate professional ethical standards.		Supports social work as a profession. Consistent in adherence to social work values and ethical standards.		Member of professional organizations. Positive in comments and actions concerning the profession. Consistent in adherence to professional values and ethical standards.		Leader in professional organizations; works to enhance the professional image of social work. Strict adherence to and promotion of professional values and ethical standards.	

4. Self discipline; ability to structure time and resources; effective utilization of personal characteristics and feelings to obtain maximum benefit of resources for client. Examples: follows through on referrals and work assignments; adheres to time commitments; prompt, organized and concise in record keeping.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Subject of frequent complaints regarding quality of service and/or negative consequences for client.		Some complaints and/or less-than-expected outcome caused by limited ability to use personal resources.		Acceptable use of self to incorporate feedback to achieve expected outcome. Acceptable use of self in achieving expected outcome; ability to incorporate feedback to achieve expected outcome.		Ability to use self in promoting positive outcomes for the client in most instances.		Consistently effective in use of self to achieve positive outcome even in adverse situations.	
5. Self evaluation: ability to objectively identify and assess own behaviors, feelings, beliefs, to impact upon service delivery.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Does not demonstrate ability to evaluate self and rarely acknowledges the need to evaluate.		Limited awareness of own behaviors, feelings, and beliefs which impact upon professional performance.		Acceptable level of self-awareness and flexibility.		Consistently demonstrates self awareness in assessing professional performance.		Demonstrates ongoing self evaluation and adaptation of self to promote positive outcome.	
6. Commitment to continued professional learning.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Demonstrates no desire for continuing professional education nor engages in research activities.		Infrequently reads professional literature. Reluctantly takes advantage of learning opportunities.		Takes initiative in seeking continuing education opportunities. Reads professional literature.		Consistently seeks continuing education experiences. Frequently reads professional literature.		Actively seeks continuing education experiences. Avid reader of professional literature.	
7. Initiative: ability to act independently.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Very dependent. Demonstrates no ability to carry out actions independently and/or avoids situations requiring independent actions. Or excessively independent. Fails to use good judgment in consulting supervisor when necessary.		Some ability to carry out actions independently if similar situation has occurred and actions can be modeled.		Willingness on most occasions to assume responsibility for independent actions.		Demonstrates increased ability to act independently and does so frequently.		Consistently demonstrates ability to act independently and seeks additional responsibilities.	

8. Ability to formulate diagnostic assessment: systematically gathers, organizes, and synthesize his data to delineate the parameters of the problem.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Does not demonstrate knowledge and use of assessment technique and rarely basis service on client needs.		Limited ability to assess problem areas; unable to discriminate relevant from irrelevant information.		Effective in most situations; is able to anticipate data needs and collect sufficient information in an organized manner to identify immediate needs; use this supervisor in difficult cases.		Gathers data systematically and efficiently, able to identify information gaps and actively seeks missing information, assesses long-term as well as immediate needs of the client system.		Exceptionally effective in identification and analysis of contributing factors in complex situation to produce a concise, sophisticated needs assessment.	
9. Ability to formulate and implement treatment (intervention) approaches: strategies for problem resolution.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Does not demonstrate knowledge or ability to use organized, effective treatment techniques; client is rarely informed about the particular approach, length of treatment and goals of treatment.		Limited ability to involve client in goal determination and to provide specific treatment according to the assessment.		Ability to develop, plan, and select most effective strategy and provide treatment and intervention at the expected level with client involvement.		Effective in providing treatment as demonstrated by evaluation of Poor Review/Quality Assurance reports, case records, client records, and reports of professional colleagues and community.		Exceptionally effective in providing appropriate treatment in the most complex circumstances through creative intervention strategies.	
10. Ability to communicate orally.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Communication is disorganized, vague, general, and irrelevant.		Expresses self well enough to be understood.		Ability to organize and concisely incorporate relevant data in the presentation.		Above average ability to express self consistently in an organized manner with concise, relevant presentation of data.		Ability to communicate based on an understanding of sociocultural differentials such as ethnicity and age; ability to use appropriate language in a clear manner.	
11. Ability to communicate in writing.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Communication is disorganized, vague, general, and irrelevant.		Expresses self well enough to be understood.		Ability to organize and concisely incorporate relevant data in the presentation.		Above average ability to express self consistently in an organized manner with concise, relevant presentation of data.		Ability to communicate based on an understanding of sociocultural differentials such as ethnicity and age; ability to use appropriate professional language in a clear manner.	

12. Ability to establish effective professional relationships with clients: promotes conditions fostering trust in a professional relationship that allows for growth, self discovery, and change.										
0	1	2	3	4	5	6	7	8	9	10
NOT ABLE TO OBSERVE	Demonstrates difficulties in establishing relationships; allows unproductive situations to develop.		Demonstrates the ability to relate appropriately and constructively with clients, but occasionally has problems showing objectivity.		Demonstrates the purposeful use of self and client in developing, maintaining, and terminating professional relationships.		Consistently demonstrates sensitivity to issues in client/professional relationship; ability to establish and maintain rapport with clients, ability to recognize factors within the client and self that impact the professional relationship; ability to use factors in a creative way to promote the relationship and the achievement of the goal. Consistently maintains sensitivity and perceptivity in listening to clients feelings; uses own experiences and perceptions therapeutically with client.		Demonstrates non-judgmental acceptance and consistently develops positive, productive professional relationships including the most difficult clients.	

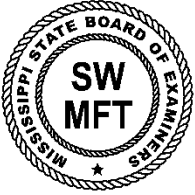
Please make additional comments (required): _____

Date and Location of Onsite Visit (required): _____

This evaluation has been discussed with
me and I have received a copy of it.

Signature of Supervisor / Date

Signature of Supervisee / Date



Mississippi
Board of Examiners for
Social Workers and Marriage & Family Therapists
Jackson, MS 39296-4508
Post Office Box 4508
601-987-6806/Fax: 601-987-6808
www.swmft.ms.gov

REQUEST FOR FINGERPRINT CARD

INSTRUCTIONS: Complete this form and return to our office. Once this form is received with payment, we will mail you a fingerprint card. After getting your fingerprints added onto the card, be sure to fill out the descriptive information including signing the card, printing your name, your date of birth and social security number (as these spots are often overlooked). The fully completed card should be mailed to: Mississippi Board of Examiners for SW/MFT, P.O. Box 4508, Jackson, MS 39296-4508. Please do not allow the fingerprints to smudge.

Mark one: ☐ Applicant for social work license
 ☐ Applicant for LMFT license
 ☐ Applicant for LMFTA license
 ☐ License Renewal: license # _____
 ☐ Reinstatement: license # _____

I, _____, request that a fingerprint card be sent to me at the address listed below. I have enclosed the required \$50.00 processing fee, payable by money order or cashier's check to MBOE. I understand that the information received from both the Mississippi Criminal Information Center and the Federal Bureau of Investigations concerning my criminal history records check via fingerprint records will be reviewed and may affect the approval of my application for licensure, reinstatement or the status of the renewal of my license.

Mailing Address: _____

Phone: _____

I understand that it may take 4-6 weeks for my fingerprints to be processed by the MS Dept. of Public Safety. I understand that there may be delays in the processing of my fingerprint card if my fingerprints are unreadable and that will extend the processing of my background and sex registry check beyond 4-6 weeks.

Signature

Date

For Office Use Only:

CC, MO, TC, OC #: _____ Amount: \$ _____ Date: _____

Name on payment, if different from licensee: _____

Acceptable Fingerprint Card Example

Completed cards should be mailed to: MBOESWMFT, P.O. Box 4508, Jackson, MS 39296-4508.

APPLICANT <small>For Applicant's Use Only</small> (FD-256 (REV. 5-1-00) 1110-10648) SIGNATURE OF PERSON FINGERPRINTED <i>Jane E. Doe</i> RESIDENCE OF PERSON FINGERPRINTED 425 Adams Court Lark, MS 38770 DATE 1/5/14 SIGNATURE OF OFFICIAL TAKING FINGERPRINTS <i>Sharon Linphry</i> EMPLOYER AND ADDRESS 837 4th Street Merry, MS 38740 REASON FOR FINGERPRINTING Applicant of SW or MFT Licensure, Miss. Code Ann. Section 73-53-11		TYPE OR PRINT ALL INFORMATION IN BLACK LAST NAME: <i>DOE</i> FIRST NAME: <i>JANE</i> MIDDLE NAME: <i>ELLA</i> ALIASES: AKA MS920476Z BD EXAM SOCIAL WORK JACKSON, MS CITIZENSHIP: CTZ USA YOUR NO.: OCA FBI NO.: FBI ARMED FORCES NO.: MNU SOCIAL SECURITY NO.: SOC 123-45-6789 MISCELLANEOUS NO.: MNU		FBI LEAVE BLANK DATE OF BIRTH: DOB MONTH DAY YEAR 01 02 2001 PLACE OF BIRTH: POB Flowood, MS
		LEAVE BLANK CLASS: _____ FILE: _____		

